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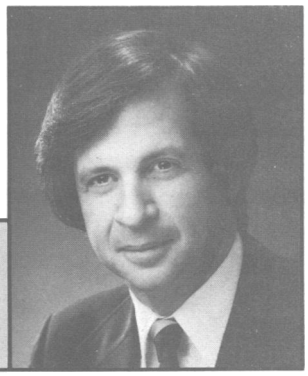

Who's Really Caring For Our Patients?

Marshall B. Block, M.D.

After admitting a patient early one morning to the hospital, I was leaving the floor when a nurse said to me, "Don't worry, Dr. Block, we'll take good care of your patient." As I was walking toward the elevator I thought about that comment and thought that she really was correct without even knowing it. Not that she was going to take *good care* of my patient, but rather that she was going to *care* for my patient. Nurses are the ones who are actually caring for our patients.

As an example, Mrs. Jones is admitted to the hospital in the middle of the night with a chief complaint of shortness of breath and chest pain. She is admitted to the Intensive Care Unit after her vital signs are taken in the Emergency Room and she is examined by the Emergency Room physician. He in turn has called the attending physician who agrees that the acute nature of the patient's symptoms and a chest x-ray showing bilateral pleural effusions suggests the presence of congestive heart failure. The patient is brought by a nurse to the Intensive Care Unit. She is then admitted by the nursing staff of the Intensive Care Unit, who do all of the necessary chores and monitor the patient using telemetry until the attending physician arrives at 6:00 in the morning. He observes the patient's clinical signs and her response to the therapy that was instituted in the Emergency Room and writes additional orders for care during the rest of the day. He writes contingency orders so that if certain situations arise he is to be called for follow-up orders. He then leaves the floor either to see additional patients or return to his office for a busy day caring for patients. The nursing staff follows his orders and brings the patient her breakfast tray, then gives her insulin since she is a diabetic, and follows the intravenous fluid orders and other intravenous medications that have been prescribed. They bring her bedpan and they remove it and empty it. They check her vital signs three or four times during the morning, and present her with her luncheon tray. The attending physician, because of his concern for the unstable nature of her cardiovascular status, returns to see her at noon and writes additional orders based upon the results of the laboratory studies which were returned from early morning. In the afternoon, shifts change and a new nursing staff arrives and begins to review the patient's clinical status.

This sequence of events occurs three times a day while every one of our patients is hospitalized, either in the Intensive Care Unit or on the floors. As attending physicians we see the patient, usually in the morning but on occasion twice or even three times a day, depending upon the clinical status of the patient. The amount of time we spend with the patient is small compared to the time the patient is in the hospital every day. True, we write orders in the chart and review laboratory and radiological studies as they return

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Use of Automatic External Defibrillators

Use of automatic external defibrillators (AEDs) by emergency medical personnel may facilitate treatment for more victims of heart attacks, according to a study reported recently in *JAMA*. The study found that automatic devices required less training for proper use and that they delivered shock to the heart one minute faster than standard defibrillators.

Richard O. Cummins, M.D., M.P.H., M.S.C., of the University of Washington, Seattle, and colleagues, compared the effectiveness of both kinds of defibrillators used by emergency medical technicians (EMTs) in treating 321 patients with cardiac arrest. In their study, 116 patients were treated with AEDs, and 158 were treated with standard defibrillators (an additional 47 were treated by EMTs using the standard defibrillator even though they were assigned to use the AED).

Hospital admission and discharge rates of patients were comparable regardless of the type of device used. "The only significant difference observed was in the time from power on to first shock: 1.1 minutes average AUTO group and 2.0 minutes average standard group," the researchers say.

"Automatic external defibrillators appear to have advantages over standard defibrillators in training, skill retention, and faster operation," the report adds, noting that AEDs can make early defibrillation available for a much larger portion of the population.

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Editor's Message

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to the chart on behalf of the patient, but our actual expenditure of time with the patient is not great, and the amount of "caring" that we do is small.

Watching many attendings berate nurses (I've been guilty of this myself) leads me to suggest that we really are off base. We need to be sure that the nursing staff at every hospital is carefully selected and given responsibilities commensurate with their abilities. Furthermore, we should have compassion and understanding for the difficult task they must undertake on a daily basis caring for our sick patients. I believe we have lost sight of the role that the nurse plays in the overall scheme of things and they should be given a greater attention and reward for their efforts. If it were not for the nursing staff at every hospital, our patients would not get the care we are prescribing. It wouldn't hurt to say, "Thank you, for caring for my patient," when you see a good job being done by the nursing staff. They need our support and we need theirs. ■

Marshall B. Block, M.D., Editor

President's Message

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and ArMA urge physicians to consider each patient's financial needs when setting charges and to accept Medicare assignment, reduce fees, or charge no fee at all in cases of true financial hardship.

Physician reimbursement must be more predictable and less inequitable. It is past time we had a resource-based relative value scale based on actual costs including factors such as the time required to provide a service, the complexity of the service, the training, equipment and overhead expense required to provide the service and the risk involved. Congress is working "at" it.

2.) Patients must be aware of cost and co-pay more when appropriate. When the Medicare system is threatened financially, there is no justification for subsidized care to those who are well-to-do. A "means test" may not be popular but it's good for the system. Medical research for better treatment in the near future and the education of new physicians are at risk in the current system that fails to realistically reimburse for medically indicated care.

Patients must be reminded that in our pluralistic society they will not be well-served by being forced into a particular delivery system based on the federal government's administrative convenience or perceived cost savings.

3.) The government must be persuaded to stop rearranging the deck chairs and do what's necessary to save sinking Medicare with sound fiscal policy (see AMA: *Proposal for Financing Health Care of the Elderly,* Report of the Board of Trustees to the House of Delegates Annual Meeting, Chicago, Illinois, June 1986.) It is long overdue!

Remember, *we* are the government and your patients are voters, too. Lobby them. If, as a physician, you perceive politics to be beneath you — reconsider Rudolf Virchow's observation that "medicine is in essence a social science and politics is nothing more than medicine on a larger scale."

Expand your practice a little! ■

Neil O. Ward, M.D., President